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Policing ‘Vancouver’s Mental Health Crisis’: A Critical Discourse Analysis

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Abstract

In Canada and other western nations there has been an unprecedented expansion of criminal justice systems and a well documented increase of contact between people with mental illness and the police. Canadian police, especially in Vancouver, British Columbia, have been increasingly at the forefront of discourse and regulation specific to mental health. Drawing on critical discourse analysis, this paper explores this claim through a case study of four Vancouver Police Department (VPD) policy reports on “Vancouver’s mental health crisis” from 2008–2013, which include recommendations for action. Analyzed is the VPD’s role in framing issues of mental health in one urban space. This study is the first analysis to critically examine the VPD reports on mental health in Vancouver, B.C. The reports reproduce negative discourses about deinstitutionalization, mental illness and dangerousness that may contribute to further stigma and discrimination of persons with mental illness. Policing reports are widely drawn upon, thus critical analyses are particularly significant for policy makers and public health professionals in and outside of Canada.

Keywords

Mental Health; Policing; Policy; Dangerousness; Critical Discourse Analysis; Institutionalization

In Canada and other western nations there has been an unprecedented expansion of criminal justice systems and a well documented increase of contact between people with mental illness with the police (Chappell, 2010; Hartford et al., 2005). These developments have been accompanied by a growth in neoliberal policies and cutbacks to health services, housing, and other social and economic supports (Gaetz, et al., 2014; Grabb & Hwang, 2009). Linked to these factors, Canadian police, especially in Vancouver, British Columbia, have been increasingly at the forefront of discourse and regulation specific to mental health (MHCC, 2014). This paper explores this claim through a case study of four Vancouver Police Department (VPD) policy reports on “Vancouver’s mental health crisis” from 2008–2013, which include recommendations for action. Analyzed is the VPD’s role in framing issues of mental health in one urban space.

Police knowledge and discourse on mental health “sets itself above other knowledges” (Smart, 1989, p. 10), and is widely drawn upon (McCulloch, 2000; Chappell, 2010); thus, critical analyses of police reports are particularly significant for policy makers and public health professionals in and outside of Canada. In the pages that follow, the VPD policy reports and their setting are introduced, followed by an exploration of the role of the VPD as vocal claims makers, and discourses of deinstitutionalization, re-institutionalization, increased regulation, dangerousness and mental health.

The Setting

Three of the VPD reports analyzed in this paper are focused on the city of Vancouver while a fourth centres on Vancouver’s Downtown Eastside (DTES), an inner city space that we describe in more detail below. References to Vancouver in the four VPD reports, however, often appear as shorthand for the DTES. Significantly, all of the reports intersect while advancing similar discourse and recommendations. Vancouver is the third most populated metropolis in Canada and one of the most ethnically diverse. Although the city itself is often accredited with being one of the world’s most livable places in terms of healthcare, the environment and culture (e.g. *The Economist*, 2009, 2013; *The Globe and Mail*, 2013), many people within the city struggle with unemployment and poverty (City of Vancouver, 2012). City of Vancouver reports indicate a serious homeless population (2013a, p. 8), most visibly evidenced in Vancouver’s oldest neighbourhood, the Downtown Eastside, which is located on unceded Coast Salish territory (Aboriginal territory that was never officially given up). The DTES is a socially produced space constructed by economic and municipal policy (including by-laws, policing, etc.), provincial and federal governments, historical power relations, and race, class and gender inequity (Anderson, 1990; Schatz, 2010). The DTES is notoriously typecast as a space of crime and dereliction not only by the Canadian media but also by the Vancouver Police Department (Culhane, 2003; Jiwani & Young, 2006; Liu & Blomley, 2013; Pitman, 2002; Pratt, 2005; VPD, 2009; Woolford, 2001).

Branded Canada’s poorest urban postal code, the DTES is now an impoverished area of the downtown core with a highly visible street scene (including drug selling and sex work) adjacent to the more affluent business sector. These economies are often a source of supplemental income for people but also put them in more contact with police. Compared to the rest of Vancouver, the DTES is inhabited by a significantly higher percentage of Aboriginal people, seniors, the poor, the underemployed, as well as people with mental illness and addiction (City of Vancouver, 2012). The DTES is also characterized by a high concentration of community services and single-room occupancies (SROs), some private (24 percent) and others operated by the city (9 percent) (City of Vancouver, 2012, p. 13). Many of Vancouver’s SROs in the DTES are rundown, filthy, bug-infested and tiny (City of Vancouver, 2012, p. 14). The majority of SROs do not include a private washroom or kitchen facilities. Unlike social housing in other social democracies that provide self-contained apartments, SROs in the DTES became default social housing. This choice has serious ramifications for renters. Without private kitchens, washrooms and social space (such as living rooms), the streets, alleys and community services struggle to provide what housing does not. Residents of the street scene are consequently more visible to police (in contrast to people with access to private space) and are subject to a disproportionate amount

of ticketing for by-law infractions such as panhandling, jaywalking, street vending and trespassing (King, 2013, 2014; Pivot, 2013).

The Downtown Eastside bears considerable stigma attached to both the area and the residents despite continued resistance by community members, advocates and activists to both the material conditions and the plethora of negative depictions (see Culhane, 2003; Boyd & Boyd, 2014). Liu and Blomley (2013) argue that residents of the DTES are most often defined in the media by their deficiencies and that the neighbourhood is characterized as a pathologized space framed through themes of criminalization, medicalization and socialization. This framing is significant to those with little contact with the neighborhood. As Liu and Blomley (2013, p. 120) state: “given that most urban residents have little direct experience of such places, the media play a crucial role in providing compelling descriptions, narratives, and prescriptions.” And, as is argued in this paper, the VPD also play a crucial role in framing the DTES and its residents as well as directing mental health policy.

Critical Perspectives: VPD as Claims Makers

Critical scholars illustrate how social problems (such as mental health crises) are both socially produced and constructed through representation and vocal claims makers (Best, 1995). Institutionally based claims makers, such as the Vancouver Police Department (VPD), help to define the nature of the “mental health crisis” and they also offer solutions to this problem that correspond with their institutional priorities and concerns (Best, 1995), reinforcing technologies of social control. Scholars have also brought our attention to how police organizations utilize corporate communication strategies to convey their institutional priorities and inform political debates (Chermak & Weiss, 2005). The police are significant cultural producers communicating dramatized stories about urban space, crime, and mental illness (Linnemann & Kurtz, 2014). Constructed as “‘frontline soldiers’ between order and chaos,” (Linnemann & Kurtz, 2014, p. 342) the “police begin in a winning position with the power to [produce] diagnose, classify, authorize and represent” social problems (Loader in Linnemann & Kurtz, 2014, p. 341).

The VPD are particularly well positioned to frame, define and offer remedies to the problems that they themselves have constructed (see Boyd & Carter, 2015; Chermak & Weiss, 2005). Indeed, Linden et al. (2012) in their survey of 99 academic and non-academic publications on the DTES from 2001–2011 found that some research is considerably more influential than others in effecting policy change. They call attention to two of the VPD reports analyzed in this paper, *Lost in Translation* (Wilson-Bates, 2008) and *Policing Vancouver’s Mentally Ill* (Thompson, 2010), noting in particular that they are widely cited and also that the City of Vancouver “borrows heavily” from these reports in the creation of housing policy (Linden et al., 2012, p. 564–565). This can be seen in recent local health authority (Vancouver Coastal Health, 2013) and B.C. Ministry of Health (2013) reports, which draw heavily upon VPD reports (specifically, Thompson, 2010; VPD, 2013; Wilson-Bates, 2008).

Likewise, following the VPD's most recent 2013 report, the City of Vancouver published the *Mayor's Task Force on Mental Health and Addictions: Terms of Reference* (2013b), which details the creation of a Task Force made up of the City, Vancouver Coastal Health, the Vancouver Police Department, and 'other related sectors' for the purpose of creating "feasible actions" to address the needs of "seriously addicted and mentally ill (SAMI) residents in Vancouver" (City of Vancouver, 2013b, p. 1). The report's five objectives closely mirror the recommendations of the 2013 VPD report (discussed below) (Mayor's Task Force, 2013b, p. 2; VPD, 2013, p. 2, 31, 32).

Liu and Blomley (2013) note that certain social actors or claims makers (such as the VPD) are privileged over others in the media's framing of social problems and spaces. In particular, Vancouver's DTES is most often framed by spokespersons from outside (rather than from within the community) and this serves to justify certain characterizations of the problems and resultant solutions for the neighbourhood. Amidst a range of claims makers identified by Liu and Blomley (2013, p. 127) such as government officials, politicians, business owners, community activists, individuals and non-profit organizations, claims made by the police are most prominent and also most privileged in print media's framing of the DTES. Menzies (1987) discusses the reproduction of moral panics, for instance, as a police tactic, by emphasizing danger and mental illness through "dramatic communications designed to magnify the subjective madness and dangerousness of their subject" (p. 446).

Methodology

Carol Bacchi (2009) provides some insights into how social problems such as mental health are problematized and how solutions are actualized in policy. Her analysis is grounded in Foucauldian understandings of governmentality and discourse analysis. She "directs attention to the ways in which particular representations of 'problems' play a central role in how we are governed" (2009, p. xi). Bacchi's framework is useful for our analysis of the VPD reports and we draw from questions introduced by her. Following Bacchi (2009) we ask:

1. What is the problem represented to be in the VPD reports?
2. What presuppositions or assumptions underlie this representation of the 'problem' in the reports?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation?
5. What effects are produced by this representation of the 'problem' by the VPD?
6. How/where has this representation been produced, disseminated and defended by the VPD?

Bacchi's framework for policy analysis provides an "opportunity to question taken-for-granted assumptions" within policing, government and health policies related to mental health (2009, p. xv). Bacchi argues that it is assumed that policy *solves* social problems. In contrast to this perspective, she argues that "policies *give shape* to 'problems'"; they do not necessarily address them (Bacchi, 2009, p. x, italics in original). By addressing the questions

outlined above, we investigate how concepts of mental health advanced by the VPD give shape to, and are central to, the problem of the mental health crisis in the city of Vancouver. We have included a brief description of each of the VPD reports below in order to offer further context.

VPD Reports 2008–2013

The reports summarized below were developed by the VPD in response to their heightened concern with what they identify as a “marked increase” in contact with people deemed to be mentally ill in Vancouver, B.C., and in particular, the DTES (Wilson-Bates, 2008, pp. 1-2). The first report was released in 2008.

1. Lost in translation: How a lack of capacity in the mental health system is failing Vancouver’s mentally ill and draining police resources (Wilson-Bates, 2008)

Lost in Translation is a 58-page report that argues that failures in the mental health system are resulting in a ‘marked increase’ in police interaction with people with mental illness, which is significantly draining police resources. Cost is a paramount concern in the report and police efforts in this regard are represented as an unnecessary organizational and financial burden. The report draws from narratives, photos and survey data collected by the VPD to support its claim. Firstly, anecdotal observations of calls for police service in the city of Vancouver in the first eight months of 2007 suggested a marked increase in low-level offences (e.g. panhandling) involving people who were mentally ill. Secondly, “a summary of data collected over a sixteen-day period from 9 September 2007 to 24 September 2007 of police incidents that involved a person who was suffering from the effects of mental illness” was analyzed, making up the basis of the report (Wilson-Bates, 2008, p.1). The author notes that up to 49 percent of VPD service calls during this study period involved a person with mental illness (Wilson-Bates, 2008, p. 2). Diagnoses of mental illness were subjective, rather than confirmed. In other words, police themselves determine mental illness rather than a medical professional. However, the report makes clear that under the British Columbia Mental Health Act, police officers “are afforded the power to apprehend a person based on their observation” (Wilson-Bates, 2008, p. 1).

The document argues that “excessive” police interaction as “front line mental health responders” has three contributing factors all attributed to the failure of the mental health system: a lack in the mental health system to adequately deal with the loss of resources following deinstitutionalization; lack of information sharing between the mental health system and the police; and reluctance to detain/institutionalize people against their will. For instance, the report states there is “an unwillingness on the part of service providers to fully utilize the provisions of the *Mental Health Act* due to a lack of available resources and/or personal ideology” (Wilson-Bates, 2008, p. 2). Faced with such perceived inadequacies, the report suggests there is little choice but for police intervention and further criminalization of the mentally ill, especially in the Downtown Eastside. The report concludes with a list of recommendations to address what the VPD perceives as a ‘gap’ in mental health services in Vancouver.

2. Project Lockstep: A united effort to save lives in the Downtown Eastside (VPD, 2009)

As the 60-page 2009 report title implies, one aim of *Project Lockstep* is for relevant agencies to fall in line with the VPD's recommendations in order to proceed in synchronization. The report is essentially a call for inter-agency collaboration (e.g. health, criminal justice, city-run single-room occupancy hotels and income assistance) and information sharing with the VPD in addressing critical issues in the DTES, as identified by the VPD, as well as increased policing in the area.

3. Policing Vancouver's mentally ill: The disturbing truth, Beyond Lost in Translation (Thompson, 2010)

The 34-page *Beyond Lost in Translation* (2010) report is a follow up to the 2008 *Lost in Translation* VPD report. As first responders, or as they call themselves, "society's de facto 24/7 mental health workers" (Thompson, 2010, pp. 3, 9, 12), street cops, the report argues, have experienced little change since the 2008 VPD report recommendations. Much emphasis is placed on suicide in Vancouver (as a violent act and also potentially preventable if police recommendations are taken up by health services). The report is particularly critical of the mental health system and expresses frustration with what the VPD perceive as the resistance of health agencies.

To demonstrate both the failures of the health system and the need for involuntary committal to institutional models of care over community care, three anecdotal stories of people in contact with both the police and health services are offered. These include worst-case offender narratives and depictions of those with suicidal tendencies (Thompson, 2010, pp. 18-19, 24-25). The report concludes with 12 additional recommendations.

4. Vancouver's mental health crisis: An update report (VPD, 2013)

This updated 23-page report maintains that there continues to be an increase in mental health incidents, particularly violent crimes, that police, as the first responders, must deal with and which continue to drain their resources. Much of the report works towards establishing a connection between violence and mental illness. The problem, the VPD argue once again, is a lack of collaboration by health care providers with the police and a lack of resources and capacity in the mental health system, resulting, they claim, in public disorder and a decrease in public safety. Linking violent crimes to the mentally ill, the report states: "...the trend is *alarming*, and currently poses the *greatest* risk of an unprovoked attack on citizens living low-risk lifestyles in Vancouver" (VPD, 2013, p. 2, emphases added). The solution offered by the report, justified by the presented "increase in serious, violent offences committed by the mentally ill" (VPD, 2013, p. 25) "upon innocent members of the public" (VPD, 2013, p. 1), involves additional resources in the health system for the mentally ill (including an increase in "secure care beds" or the involuntary committing of patients) (VPD, 2013, pp. 25, 26), and sharing of confidential patient information by health services to the VPD (VPD, 2013, pp. 10, 11), among other things.

Deinstitutionalization and contemporary calls for re-institutionalization: the DTES

As noted earlier, Vancouver's DTES is notoriously typecast as a space of crime and dereliction. The 2008 VPD report frames the neighborhood as both crime-ridden and plagued with mental health and addiction problems:

Drawn by cheap accommodation and access to services, [residents of the DTES] are often the victims of predatory drug dealers, abusive pimps and unsavoury landlords who take advantage of their vulnerabilities. Unable to access reasonable mental health and/or addiction services, people are frequently coming into contact with VPD officers who in turn rely on provisions in the *Criminal Code* in the absence of an acceptable response from hospitals to admit mentally ill patients. (Wilson-Bates, 2008, p. 52)

Ignoring the many successful housing and mental health and addictions services such as Insite (supervised injection site), Lookout Emergency Aid Society, Vancouver Area Network of Drug Users, the Portland Hotel Society, and Kettle Friendship Society, one primary assertion in the VPD reports is for increased police presence on the streets of the DTES in order to address the police's construction of the problem (crime and disorder) and to quell the "high levels of fear by those living, working or visiting the area" (VPD 2009, p. 24). *Lost in Translation* (VPD, 2009, p. 24) argues that increased police presence leads to greater civilian presence which in turn leads to "greater feelings of security, safety," and less crime. Such a contention, however, is countered by research on the intensification of police activities in the DTES in the past decade that claims that VPD officers engage in racial profiling and numerous human rights violations that negatively impact residents (i.e. "instances of excessive force, arbitrary arrest, harassment, and illegal searches" -see Small et al., 2006, p. 86; King, 2014; Penderson and Swanson, 2010). In fact, in the DTES marginalized people rarely view the police as "enhancing public safety" (see Armaline et al., 2014, p. 376). Police presence is also compounded by the growing presence of private police/security guards in the DTES (Boyd 2010, p. 176; Penderson and Swanson, 2010; Rigakos 2002, VPD, 2009, p. 22). Police contact, when intrusive, can also threaten the mental health of individuals who they interact with (see Geller et al., 2014). This is significant because people with mental illness come into contact with police and are arrested for minor nuisance type offences more often than the general population (Hartford et al., 2005).

Part of the stigmatization of the DTES and presumably leading to what the VPD have termed "Vancouver's mental health crisis" (VPD, 2013) is the linking of residents dealing with mental health and addictions to the recent closure of B.C.'s largest psychiatric care facility, Riverview Hospital, located just outside Vancouver. In British Columbia since the early 1970s, there has been a general policy of deinstitutionalization of people with mental health problems, exemplified in the gradual closure of Riverview Hospital over this time span. Deinstitutionalization over the past 40 years has been met with a shift towards recovery-oriented models pursued by both Canada and the U.S., including a move towards a variety of community-based mental health services in B.C. (Battersby & Morrow, 2012;

Morrow et al., 2008). The transfer process of patients to what was to be “home-like settings in communities” was jumpstarted in 2002 under the B.C. Ministry of Health’s Riverview Hospital Redevelopment Project (Morrow et al., 2010, p. 7). Thus there have been shifts in both the philosophy of care and a “reorganizing of mental health care services and delivery” from one main psychiatric hospital in B.C., Riverview Hospital, to a regionalization of mental health services throughout the province (Morrow et al., 2010, p. 7). This shift also resulted in a reorganizing of funding from the province to regional health authorities. However, sufficient funding did not accompany deinstitutionalization in B.C. Thus funding for community based services and housing has been inadequate (Ibid, pp. 61-62). A similar trend has been noted in other western nations (Chappell, 2010).

In 2008, the same year as the first VPD report on mental illness, Morrow et al. (2008, p. 1) note a change in the “political tide” in Vancouver, with pressures for psychiatric re-institutionalization due to popular and public perceptions linking mental illnesses to social problems, including “the visibility of homelessness, addictions and poverty in downtown Vancouver”. The criminalization and linking of mental illnesses to social problems by the VPD easily extends to popular discourses on the DTES where such “problems” are most *visible*. Increased visibility has led to public critiques of deinstitutionalization policies (particularly the closing of Riverview Hospital), regarded as a key contributor to mental health problems in the neighbourhood, rather than analyses of the need for a continuum of care (Morrow et al., 2008).

Morrow et al. (2008) point out that negotiating the line between social support and coercive control has been a central component in the treatment of people with mental illnesses. People with mental illness in western societies have been historically viewed as criminal, sinful, demonic and in need of moral regulation (Foucault, 1988). Indeed, Menzies maintains that these issues (and others) “remain unresolved after more than 300 years of deliberation” (2002, p. 400). Morrow et al. (2008, p. 1) state: “[c]alls for re-institutionalization reflect historic tensions between providing support and imposing control on people with mental health challenges” and it is precisely this tension that is evident in the VPD reports. VPD report *Project Lockstep* (2009, p. 13) claims that: “The biggest influencing factor on the incidence of mental illness in the community has been the deinstitutionalization of the mentally ill that began in the 1980s.” Similarly, VPD report *Beyond Lost in Translation* (Thompson, 2010, p. 5) “submits that community based treatment can hardly be described as a ‘success.’” The VPD’s direct problematization of deinstitutionalization serves as a basis for arguments advocating re-institutionalization and greater police control over those with mental health challenges, exemplified by their recommendations of restrictive tactics such as the need for “secure beds” (beds in locked facilities) under the auspices of providing increased support for the mentally ill.

There is an absence in the VPD reports of an analysis of mental illness as a disability and the interrelated connection between disability, stigma, marginalization and homelessness (see Schatz, 2010). As well, there is no recognition of the anti-psychiatry (and mad) movement’s concerns about police and medical regulation (see LeFrançois et al., 2013). The number of people living in the DTES who are homeless or living in inadequate housing, and who have a disability, is significant. Also absent from the reports are the voices of those who would be

most affected by the policy recommendations in the VPD reports, such as former patients of Riverview.

Dangerousness

Evident within all of the VPD reports analyzed are discourses of dangerousness in connection to mental illness, emphasized as evidence and support for the problems identified by the VPD (such as “the draining of police resources” (Wilson-Bates, 2008)). Negative stereotypes and representations that uncritically align dangerousness with mental illness are repeated and pronounced. For instance, in the first VPD report (Wilson-Bates, 2008), the term “danger,” in relation to the street, housing and the ‘mentally ill’ appears 15 times. A discussion of dangerousness escalates to an emphasis on violence in the 2013 VPD report, with the term “violence” repeated 22 times. The anecdotal accounts or storytelling techniques employed by the VPD reports (personal narratives being an example of this) also impart an alignment of dangerousness with mental health concerns.

The VPD state that some people with mental health problems are a particular danger to themselves. For instance, in their 2008 report they note that “half of all police-involved fatal shootings in the City of Vancouver [not just in the DTES] since 1980 involved some sort of mental illness or depression on the part of the deceased person; this is the most tragic and extreme manifestations of a mental health system that is failing” (Wilson-Bates, 2008, p. 53). Yet, similar to many of the claims presented in their four reports, this claim is misleading. The report does not make clear how many shootings there are and the claim is not referenced. In addition, the 2008 VPD report does not include consideration of potential police error or misconduct. A study by Parent (2004) is useful here, as he examines (among other factors) police use of deadly force in the City of Vancouver between 1980 and 2002. His study notes that of the 13 recorded incidents in Vancouver during this time period, roughly half involved “mental illness or an act of suicide on the part of the deceased” (Parent, 2004, p. 187). Thus, over a period of 22 years there were six or seven fatal shootings in the City of Vancouver that could be labeled “police assisted suicide” or suicide as a “result of police intervention.” Although suicide is a tragedy, we question whether six or seven police assisted suicides over 22 years can be framed as the most “tragic” example of the health care system failing.

A more pervasive alignment of violence in the VPD reports refers to violence against others. This is exemplified in the VPD 2013 report which states that the frequency of “random violent attacks inflicted upon *innocent* members of the public” by people with mental disorders is both established and increasing, due partially to the police’s inability (due to multiple obstacles) to *detain* people in psychiatric spaces (VPD, 2013, p. 18, emphasis added). It further claims that, “The increase in serious, violent offences committed by the mentally ill can be partially attributed to the reduction of secure care beds, as these are the same dangerous individuals who would have been institutionalized and would not have posed a risk to the public or themselves” (VPD, 2013, p. 25).

The linking of mental illness and violence is supported by 10 brief decontextualized anecdotal synopses of extremely violent incidents, characterized as “unprovoked savagery”

between December 2012 and July 2013, eight of which have a male suspect (VPD, 2013, pp. 18-23). In one representative synopsis the VPD describe an incident where a 30-year-old woman in a convenience store is suddenly attacked from behind with a knife. “The attack was so violent that the blade of the knife broke off inside the victim” (VPD, 2013, p. 20). Another synopsis describes several assaults on unsuspecting victims committed by a man on marijuana and prescription medication (some with a knife and some with a hammer) including that of a VPD member (Ibid., p. 19). In an early analysis of police reporting practices on mental illness, Menzies notes that their emphasis on communicating the most bizarre and outrageous “features of criminal conduct” create “powerful images that [invite] therapeutic or coercive intervention or both” (1987, p. 450), especially since, as noted earlier, most arrests are for low-level offences.

As noted above, the 2013 VPD report highlights anecdotal synopses of violent crime and homicide by people with mental disorders in Vancouver. Statistics Canada however, provides a different perspective. The homicide rates in British Columbia of accused persons *suspected* of having a mental health or development disorder have been rising slowly since the early 2000s and fell in 2012; for example in 2008, 10 people accused of homicide were suspected of mental health or developmental disorder; in 2009 the number rose to 12 people accused of homicide; and in 2012, the number decreased to eight (Statistics Canada, 2014). Unfortunately, a breakdown is not provided by Statistics Canada for the City of Vancouver. However, in 2012, the City of Vancouver’s total homicide rate was at its lowest in 18 years. In fact, over the past 25 years the homicide rate in British Columbia has declined, although there are regional variations. In Canada, the overall crime rate has also been declining since 1972. It is interesting that at the same time that homicide rates and violent crime rates are low and steadily declining in Vancouver and the rest of Canada (including other criminal code offences - outside of drug offences), the VPD is pushing forward recommendations for increased surveillance and police presence in Vancouver in response to escalating dangers arising from the “mental health crisis.”

Both the VPD’s alignment of the mentally ill with increased violence and their anecdotal evidence supporting such claims are questionable. For example, it is important to note that according to the VPD 2013 report’s two cited studies¹ supporting their argument, it is only a very small population of the mentally ill, people with psychosis, that fit with the VPD’s broader statements about the mentally ill in general. In contrast, the VPD is suggesting that all people with mental health concerns, rather than a documented few, may be a part of this violent trajectory. In addition, one of the 10 anecdotes of critical incidents in the 2013 report involves an individual in a “disturbed mental state” with no known previous contact with the law (VPD, 2013, p. 19). This example of generalized wording begs an exploration into what is equated with mental illness and how widely such definitions can be interpreted. Researchers compiling police-reported crime statistics at Canadian Centre for Justice Statistics note the complexities of defining mental illness by law enforcement:

One of the main challenges in gathering consistent data on the involvement of individuals with mental illness in the criminal justice system is selecting a precise

¹One report is 23 years old (Swanson et al. 1990); the other (undated) is a police report from Australia (Short et al.).

and common definition. That is, the types of behaviours and conditions that could be included in a definition of mental illness can vary widely, which in turn, poses challenges for targeted and meaningful data collection. (Mahony, 2011, p. 15)

Not only is mental illness a contested diagnosis but all data gathered by Statistics Canada on mental illness and homicide are determined by the investigating police officer's assessment of the individual rather than by a diagnosis from a medical professional (similar to the VPD survey conducted in 2007 discussed earlier (see Wilson-Bates, 2008)). It is also difficult to ascertain whether police profiling and greater awareness of mental health by police contributes to crime rates. Indeed Cotton and Coleman (2010, p. 303) challenge the methodology of a VPD 2007 survey reporting an unusually high percentage of police incidents involving persons with mental illness (see Wilson-Bates, 2008), compared to other urban areas in Canada. Yet these "questionable" percentages reported by the VPD — up to 49 percent of all calls are said to involve a person with a mental illness (Wilson-Bates, 2008, p. 2)— are used in later VPD reports, the media, and the City of Vancouver's task force to support deinstitutionalization and increased police regulation.

Knowles (2000) examines the production and management of mental health on the city streets of Montreal, Canada, in the late 1990s and argues that people with mental health concerns are popularly aligned with discourses of dangerousness. She notes that the general public, the media and myth-makers stir public anxieties by participating in longstanding urban mythologies linking "madness" to public safety and social danger as well as to the unprovoked, senseless and random violence that haunts the social imaginary of urban landscapes. This is problematic, she maintains, because although people with mental health problems may behave or act in ways that do not conform to highly scripted societal standards of individual public behaviour (i.e., they may act in an erratic, strange or unpredictable manner), the fact that they are perceived as acting "frighteningly" does not mean that they are necessarily a danger to themselves or others. Similarly, even in the absence of violent behaviour, Menzies discovered that police routinely emphasize dangerousness to legitimize intervention and institutionalization in the Canadian city of Toronto (1987, p. 431). The Canadian Mental Health Association (CMHA) discounts popular myths characterizing people with mental health issues as perpetrators of violence and instead argues that they are more likely to be a target for violence:

As a group, people with mental health issues are not more violent than any other group in our society. The majority of crimes are not committed by people with psychiatric illness, and multiple studies have proven that there is very little relationship between most of these diseases and violence. The real issue is the fact that people with mental illness are two and a half to four times more likely to be the victims of violence than any other group in our society. (CMHA, 2014)

Along similar lines, Knowles (2000) points out that people with mental health concerns are themselves endangered as vulnerable citizens occupying competitive spaces (for basic necessities of survival such as food and shelter) that are not adequately set up to meet their needs. For many people in Vancouver, but especially those living in the DTES, basic necessities of survival are unmet. There is substantive literature on how diagnosis and labels of mental illness result in specific forms of stigma and discrimination, and a burgeoning

literature that looks at how the very application of diagnoses and labels can constitute a form of inequity (Chappell, 2010; Ingram et al., 2013, p. 8; LeFrançois et al., 2014). Indeed, the CMHA (2014) states that persistent stigma further endangers those already struggling with mental illness. Despite the findings above, there is little in the VPD reports that speak to the experience of violence among those with mental illness or the need to protect the mentally ill from perpetrators of violence (outside of “predatory drug dealers” (e.g. Wilson-Bates, 2008, pp. 16, 46, 52)).

Those citizens without mental health concerns, on the other hand, have a privileged relationship to public space, including the ability to both deny access to certain spaces and to call for the policing of those they perceive as ‘scary’ or untoward. The unproblematic equation of mental health with violence and dangerousness in the four VPD reports is both stigmatizing and significant in that it impacts governance, policy-making and policing. As Knowles relates, “Clean, safe well-ordered cities are not incidental, they are *achieved* through the work of municipal governance and enforcement policies” (2000, pp. 53–54). Concerns for public safety, amplified by the popular and overriding association of mental illness with dangerousness, have local consequences, validating increased policing of unwanted “others” in public spaces. An example of this is the previously mentioned VPD push for increased police presence in the DTES to curtail crime and to ensure public safety (VPD, 2009, pp. 41, 42). Complicating the framing of mental illness in the VPD reports is the twining of mental health and addiction. Although there may be efforts to perceive people with mental illness as law-abiding, people who consume illegal drugs are categorized as criminal by the VPD in accordance with Canadian federal drug law.

Concluding Remarks

Our study is the first to critically examine the VPD reports on mental health in Vancouver, B.C. We acknowledge the role that police perform at times when dealing with people living with severe mental illness; however, it is the framing of the issue that is analyzed in this paper. The Vancouver Police Department has become a dominant claims maker about the mental health crisis in Vancouver. In keeping with our methodological framework for this study, we argue that the VPD reports released from 2008 to 2013 *give shape* to the problem of mental health *by* linking it to discourses of dangerousness, lack of policing resources and presence, and failure of the mental health care system (e.g. deinstitutionalization). The VPD reports are selective and purposefully “designed to reduce ambiguity and strengthen the signal of messages” to their intended audience (Menzies, 1987, p. 430).

The representation of mental health by the VPD has several *effects*. Although the VPD claim their intention is “target those most in need of help” (VPD, 2009, p. 2), the reports reproduce negative discourses about mental illness and dangerousness that may contribute to further stigma and discrimination of persons with mental illness. Critical researchers note a diagnosis of mental illness is followed by “structural forms of discrimination” (Wright et al. 2007, p. 81). The VPD reports also shift discourse and practice away from health and community supports, social supports, livable housing and peer-run organizations for those most affected. Rather, re-institutionalization and secure units in hospitals are *assumed* to be a solution, alongside increased surveillance. Thus, the VPD’s production of the mental

health crisis and their proposed solutions have material effects. At the same time that police are calling for secure units for people with mental health problems and larger policing budgets, and contrary to the solutions proposed by the MHCC (2012) (such as support for peer-run services), the Province of B.C. and Vancouver Coastal Health have cut back on peer-run services for people with mental health concerns (Carten, 2013; Yong, 2013). Meanwhile, the VPD budget continues to rise each year, and in 2014 makes up 20 percent of the total capital and operating budget for the City of Vancouver (City of Vancouver, 2014, p. 49). In contrast, community services make up five percent of the budget (Ibid.).

Although the VPD reports provide select anecdotal narratives of tragedy and violence, what is left *unproblematic* is that they fail to include the diversity of lived experience including voices of those most impacted by their policy solutions, people who have suffered from mental illness and those who have been through the psychiatric system (See Karp & Livingston, 2014; Reid, 2010). The four VPD reports support and advance biomedical/*criminal* frameworks and work against “social and structural understandings of mental health” (Ingram et al., 2013, p. 9). What is also missed is that structural inequalities are “avoidable”; they are “socially produced and structurally driven” (Ingram et al., 2013, p. 8; Whitehead & Dahlgren, 2006).

Scholars and activists have brought our attention to the expansion of criminal justice and the blending of criminal justice and mental health policy in Canada and other western nations, and the negative impact of these regimes in certain urban areas (Drucker, 2013; Knowles, 2000). Kerr et al. note that the application of intensified police enforcement (in relation to illegal drugs) can “produce harmful and social impacts” and the negative impact of intensified law enforcement is often “poorly understood or ignored by both the public, who make repeated calls for enforcement, and by politicians eager to appease their voters” (2005, p. 210). Similar arguments have been made about increased policing of people with mental health problems and the unprecedented expansion of criminal justice (Drucker, 2013).

Further indicating law enforcement’s resurgence of interest, *dissemination* of police knowledge, and current “leadership” role in the realm of mental health, in March 2014 the first Canadian conference on policing and mental health took place in Toronto, with the Vancouver Police at the forefront of this national initiative (MHCC, 2014). In addition, recent reports by the City of Vancouver’s task force on mental health and addictions includes five primary objectives that closely mirror the recommendations of the 2013 VPD report (2013b). Of note is that the VPD is an established and dominant claims maker particularly positioned to influence the public and health policy in Vancouver, the DTES, and elsewhere.

We conclude that the VPD reports contribute to a widening net of social control, rather than to the betterment of the lives of people living with mental illness. Considerations to how police discourse gives shape to problems, providing solutions in line with their institutional practices, is critical in and outside of Canada as police claims are widely disseminated to the public and carry significant weight in popular and public health discourses and policy-making.

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